Maryland Cancer Fund

Cancer Treatment Grant

Application Process

Maryland Department of Health & Mental Hygiene

Prevention and Health Promotion Administration

Center for Cancer Prevention and Control

Introduction

The **Maryland Cancer Fund** (MCF) provides Cancer Treatment Grants to eligible organizations for low-income Maryland residents.

Who Can Apply

- Eligible Organizations are:
  - Local Health Departments
  - DHMH CCPC-funded programs (for example, the local Breast and Cervical Cancer Programs, the Cigarette Restitution Fund Local Public Health Programs, and Maryland Colorectal Cancer Control Program grantees)

Who Can Apply (cont.)

- Eligible Patients:
  - Are Maryland residents
  - Have a family income less than 250% of the federal poverty level (See http://familiesusa.org/product/federal-poverty-guidelines for the current federal poverty guidelines)
  - Have a diagnosis of cancer within 6 months of the application date or a finding suggestive of cancer.

Grant Awards

- Grant Awards are used to pay:
  - Health Insurance Costs
    - Any health insurance policy
    - For deductibles, coinsurances, copays
  - Direct Costs
    - For cancer diagnosis and treatment
    - Up to $20,000 for direct costs
  - Indirect Cost
    - For additional expenses
    - Up to 7% of direct costs

Grant Awards (cont.)

- Award Period
  - 1 year
  - Established in Standard Grant Agreement
- Award Availability
  - Funds are limited
  - Contact MCF Coordinator **BEFORE** submitting application

Fund Availability

- MCF is funded solely by donations
- Donation levels vary
- Total # of Grant Awards are based upon donation levels
- If the applicant receives Cigarette Restitution Funds (CRF) allocated for treatment of targeted cancers, the CRF funds must be exhausted or obligated prior to applying for the MCF

Application Process

1. Contact MCF Coordinator for fund availability
    a. Call (410) 767-6213
    b. If funds are available, then you will receive a grant number to continue (**The application must be received within 30 days; If not, the funds will be released)**
    c. If funds are unavailable, then further instructions will be provided

Application Process (cont.)

2. Complete MCF application (For instructions http://phpa.dhmh.maryland.gov/cancer/Pages/mcf_grants.aspx)

3. Submit signed Standard Grant Agreement

Application Forms

1. Organization Application

2. Cancer Treatment Application

3. Proof of Income or Statement Certifying No Income

4. Proof of Residency

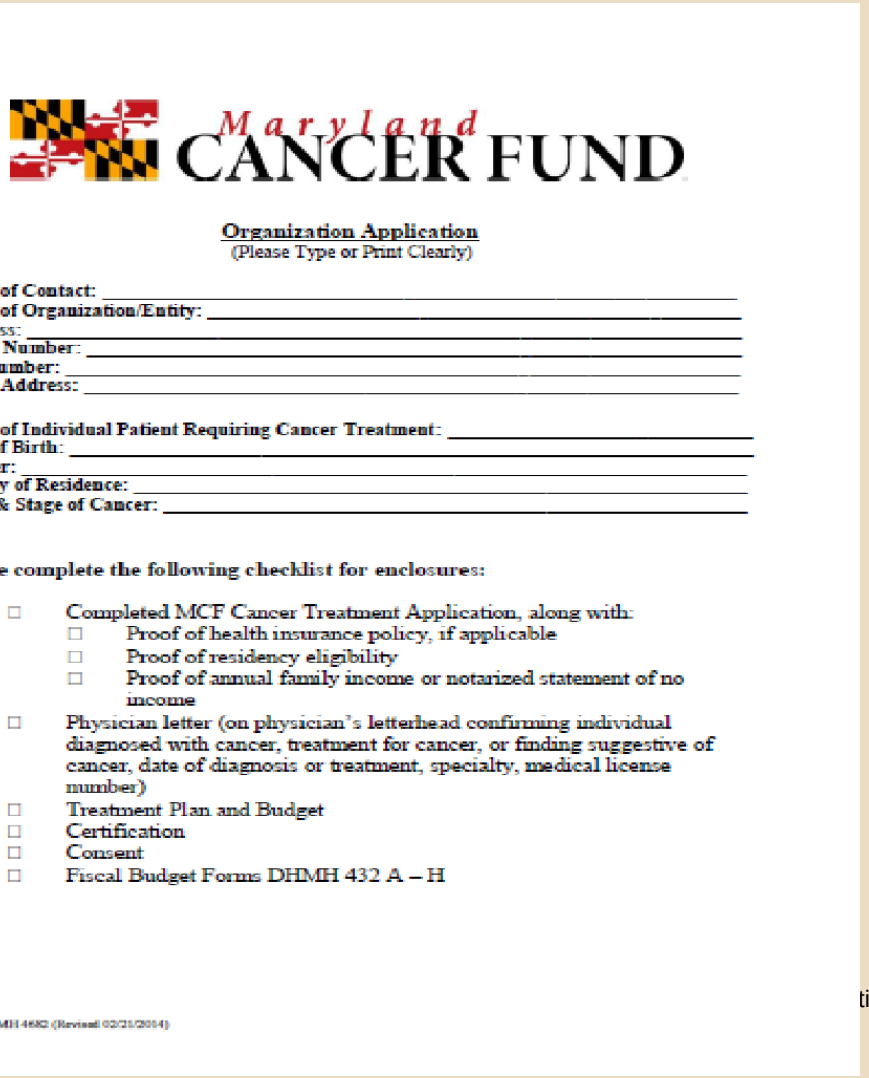
Application Forms (Cont.)

5. Physician Letter – Certification of Diagnosis
6. Cancer Treatment Plan and Budget
7. Certification
8. Consent Form
9. Fiscal Budget Forms (DHMH 432 A-H)

1. Organization Application

- Form DHMH 4682
- http://phpa.dhmh.maryland.gov/cancer/Documents/Form_4682.pdf

Organization Application - Form



Maryland CANCER FUND

Organization Application
(Please Type or Print Clearly)

Name of Contact: _____
Name of Organization/Entity: _____
Address: _____
Phone Number: _____
Fax Number: _____
Email Address: _____

Name of Individual Patient Requiring Cancer Treatment: _____
Date of Birth: _____
Gender: _____
County of Residence: _____
Type & Stage of Cancer: _____

Please complete the following checklist for enclosures:

- ☐ Completed MCF Cancer Treatment Application, along with:
  - ☐ Proof of health insurance policy, if applicable
  - ☐ Proof of residency eligibility
  - ☐ Proof of annual family income or notarized statement of no income
- ☐ Physician letter (on physician's letterhead confirming individual diagnosed with cancer, treatment for cancer, or finding suggestive of cancer, date of diagnosis or treatment, specialty, medical license number)
- ☐ Treatment Plan and Budget
- ☐ Certification
- ☐ Consent
- ☐ Fiscal Budget Forms DHMH 432 A – H

Form DHMH 4682 (Revised 02/25/2014)

2. Cancer Treatment Application

- Form DHMH 4683
- http://phpa.dhmh.maryland.gov/cancer/Documents/Form_4683.pdf

Cancer Treatment Application (cont.)

Maryland Department of Health and Mental Hygiene

Maryland CANCER FUND

Cancer Treatment Application

PLEASE COMPLETE ALL AREAS OF THE APPLICATION, Pages 1-3
(If some areas do not apply, please mark "not applicable" or "N/A")

Instructions:

PAGE 1: **RESIDENCY ELIGIBILITY** – The patient must provide proof of Maryland residency for 6 months prior to the application date. Please provide a copy of ONE of the following documents displaying patient's name AND current home address:

- Maryland Driver's License
- Maryland State Identification Card
- Lease or Rental Agreement
- Property Tax Bill
- Motor Vehicle Registration
- Paycheck or Stub with Full Name and Home Address
- Utility Bill
- Voter Registration Card
- W-2 Statement (issued not more than 12 months ago)

HEALTH INSURANCE– The patient **may** have any health insurance at the time of application and **may** remain insured during the time of service delivery.

PAGE 2: **ANNUAL FAMILY INCOME** – The patient must have an annual family income of not more than 250 percent of the federal poverty guidelines. Please list the total amount received from all sources of income before taxes are withheld.

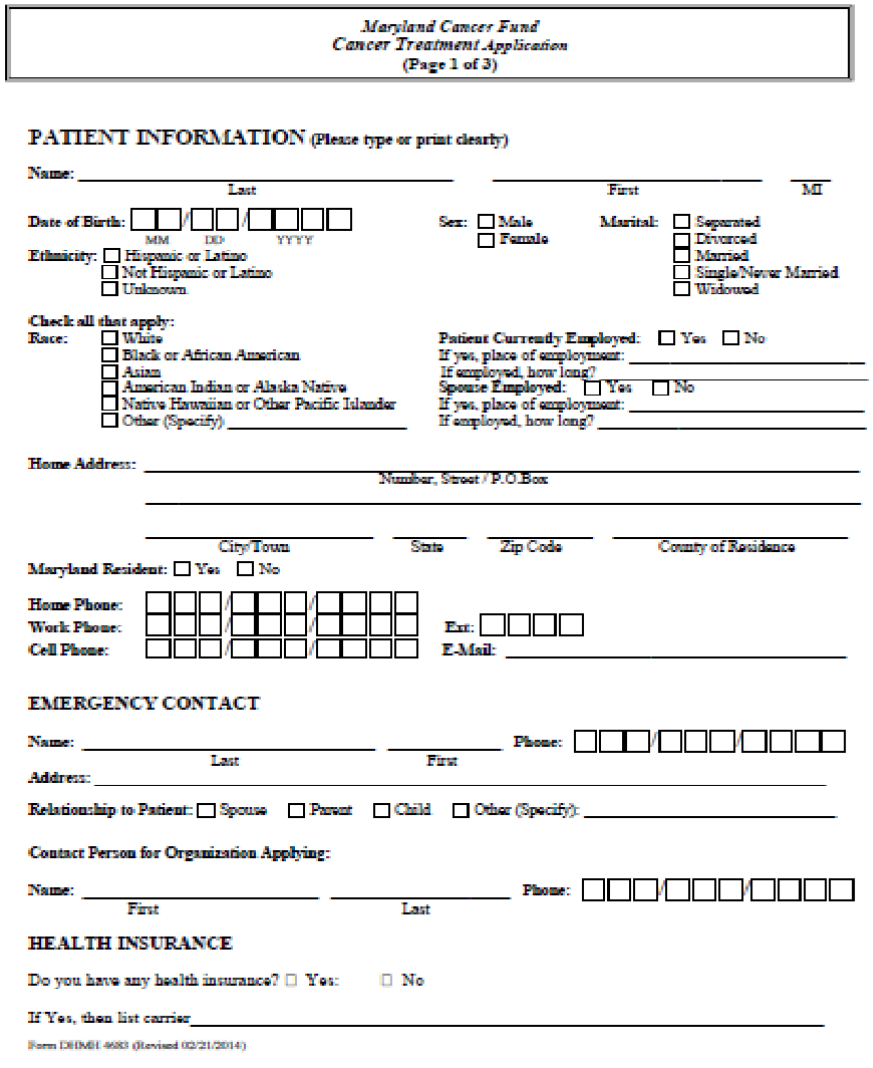
FINANCIAL ELIGIBILITY
Please provide a copy of ONE of the following documents displaying patient's name AND current home address:

- **Most Recent Pay Stubs** – Must be for two pays in a row or two pays in the same month
- **Most recent income tax return**
- **Most recent W-2 form**
- **Social Security Entitlement Letter** – The Social Security Administration sends this by mail each January. It lists the amount the patient will receive each month.
- **Notarized Statement** – If the patient is not working, this statement should state that the patient is **not** working and does **not** have **any** income, or that the patient has not had any income in the past 6 months. This is a legal document and must be stamped and signed by a notary public. (See sample patient's statement DHMH Form 4685).

PAGE 3: **PATIENT AGREEMENT** – Please read carefully because the application is a legal document. The patient's signature indicates: (1) the statements that the patient made are true; (2) the MCF has the patient's permission to verify the patient's information provided; and (3) the organization applying on behalf of the patient has the patient's permission to release information regarding the patient's medical, financial, and insurance information to in the MCF.

INFORMATION CONTAINED IN THIS APPLICATION IS CONFIDENTIAL

Form DHMH 4683 (Revised 02/21/2014)



Maryland Cancer Fund
Cancer Treatment Application
(Page 1 of 3)

PATIENT INFORMATION (Please type or print clearly)

Name: _____ (Last) _____ (First) ____ (MI)

Date of Birth: ☐☐/☐☐/☐☐☐☐ (MM/DD/YYYY) Sex: ☐ Male ☐ Female Marital: ☐ Separated ☐ Divorced ☐ Married ☐ Single/Never Married ☐ Widowed

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Check all that apply:
Race: ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other (Specify) _____

Patient Currently Employed: ☐ Yes ☐ No
If yes, place of employment: _____
If employed, how long? _____
Spouse Employed: ☐ Yes ☐ No
If yes, place of employment: _____
If employed, how long? _____

Home Address: _____ (Number, Street / P.O.Box)
_____ (City/Town) _____ (State) _____ (Zip Code) _____ (County of Residence)

Maryland Resident: ☐ Yes ☐ No

Home Phone: ☐☐☐/☐☐☐/☐☐☐☐
Work Phone: ☐☐☐/☐☐☐/☐☐☐☐ Ext: ☐☐☐☐
Cell Phone: ☐☐☐/☐☐☐/☐☐☐☐ E-Mail: _____

EMERGENCY CONTACT

Name: _____ (Last) _____ (First) Phone: ☐☐☐/☐☐☐/☐☐☐☐

Address: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Other (Specify): _____

Contact Person for Organization Applying:

Name: _____ (First) _____ (Last) Phone: ☐☐☐/☐☐☐/☐☐☐☐

HEALTH INSURANCE

Do you have any health insurance? ☐ Yes: ☐ No

If Yes, then list carrier _____

Form DHMH 4683 (Revised 02/21/2014)

Cancer Treatment Application (cont.)

Maryland Cancer Fund
Cancer Treatment Application
(Page 2 of 3)

ANNUAL FAMILY INCOME: The total received per year from all sources of income before taxes are withheld.

	INCOME (Please indicate week, month or year)				FOR OFFICE USE ONLY DOCUMENTATION
Patient Income (Includes Social Security and any other retirement benefits)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: ____
Spouse's Income (Includes Social Security and any other retirement benefits)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: ____
Parents' Income (If patient is a dependent child on parents' income tax return)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: ____
Child Support	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: ____
Foster Child Supplement (If child(ren) counted in household composition)	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: ____
Unemployment Insurance ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.	Start Date: End Date:	☐Yes ☐No ☐N/A Initial: ____
Workman's Compensation ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.	Start Date: End Date:	☐Yes ☐No ☐N/A Initial: ____
Social Security Disability Insurance ☐dependent child ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial: ____
Alimony ☐patient ☐spouse ☐parent	$.	☐ Week ☐ Month ☐ Year	Yearly Total: $.		☐Yes ☐No ☐N/A Initial:
TOTAL ANNUAL FAMILY INCOME			$.		

FINANCIAL ELIGIBILITY

To determine your financial eligibility for this program, we need to collect information regarding household composition and family income. PROOF OF INCOME MUST BE ATTACHED – (Your most recent Income Tax Return is preferred. Otherwise, provide your W-2 Forms, Social Security Entitlement Letter, a minimum of 2 pay stubs in a row or 2 pays in the same month, or a notarized letter stating "No Income and No Employment" can be substituted).

FAMILY COMPOSITION

Please list the names and ages of all family members within the household and indicate their relationship to the patient. Include: patient, spouse, financially dependent child(ren) and all other dependents listed on your income tax return form. If the patient is a child, include: child, parent, foster parent, or guardian, sibling(s).

	LAST NAME	FIRST NAME	AGE	RELATIONSHIP TO PATIENT
1.				
2.				
3.				
4.				
5.				

If there are more than five (5) family members within the household, please continue the list on a separate sheet and attach.

Total number of people in family, including patient: ☐

Form DHMH 4683 (Revised 02/21/2014)

Maryland Cancer Fund
Cancer Treatment Application
(Page 3 of 3)

PATIENT AGREEMENT

(Please read carefully before signing)

I certify that all the information on this form is true, correct and complete. I understand that any false statements would subject me to penalties under State law and would result in a denial of grant eligibility.

I authorize the Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control, Maryland Cancer Fund (MCF) to verify any information provided by me on this form. I will provide proof of any information on this form as required by the MCF.

I agree to allow the _____
Name of Organization

to release the medical/financial/insurance information regarding my cancer treatment and the Maryland Department of Health and Mental Hygiene that administers the Maryland Cancer Fund.

Signature of Patient or Parent/Guardian

Name of Contact Person for Organization Applying (Please Print or Type)

Name of Patient (Please Print or Type)

Address of Contact Person (Please Print or Type)

Date of Application

Office Phone of Contact Person

RETURN COMPLETED MCF APPLICATION TO:

Maryland Cancer Fund
Maryland Department of Health and Mental Hygiene
201West Preston Street, Room 306
Baltimore, Maryland 21201

For questions, please call (410) 767-6213

INFORMATION CONTAINED IN THIS APPLICATION IS CONFIDENTIAL

Form DHMH 4683 (Revised 02/21/2014)

3. Proof of Income

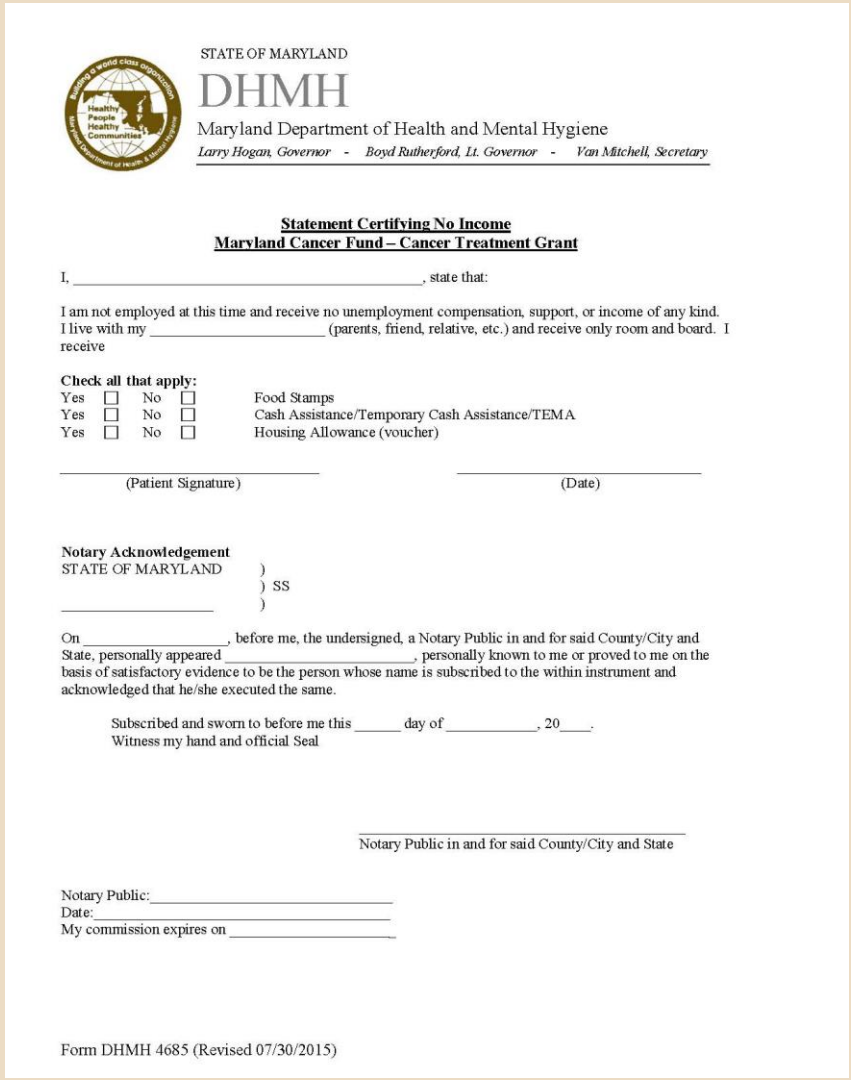
- Proof of annual family:
  - Most recent income tax return
  - Most recent W-2 form
  - Pay stubs for two consecutive pays or two pay within the same month
  - Social Security entitlement

- NOTE: When a copy of the applicant's most recent income tax return is submitted as proof of income, the form must be signed; or if filed electronically, the electronic filing verification form must be attached.

Statement Certifying No Income

- For patients with no income
- Notarized letter stating that the individual is not working and has no income
- http://phpa.dhmh.maryland.gov/cancer/CCPC%20Library%20Doc/Form%20DHMH%204685_1.pdf

Statement Certifying No Income - Form



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

Statement Certifying No Income
Maryland Cancer Fund – Cancer Treatment Grant

I, _____, state that:

I am not employed at this time and receive no unemployment compensation, support, or income of any kind. I live with my _____ (parents, friend, relative, etc.) and receive only room and board. I receive

Check all that apply:

Yes ☐ No ☐ Food Stamps
Yes ☐ No ☐ Cash Assistance/Temporary Cash Assistance/TEMA
Yes ☐ No ☐ Housing Allowance (voucher)

_____ _____
(Patient Signature) (Date)

Notary Acknowledgement
STATE OF MARYLAND)
) SS
_____)

On _____, before me, the undersigned, a Notary Public in and for said County/City and State, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged that he/she executed the same.

Subscribed and sworn to before me this _____ day of _____, 20____.
Witness my hand and official Seal

_____
Notary Public in and for said County/City and State

Notary Public:_____
Date:_____
My commission expires on _____

Form DHMH 4685 (Revised 07/30/2015)

4. Proof of Residency

- Show residency for at least 6 months prior to the application date
- Proof of current Maryland residency
  - Maryland driver's license or State identification card
  - Lease or rental agreement
  - Property tax bill
  - Motor vehicle registration
  - Pay check or stub with name and home address
  - Utility bill
  - Voter registration card
  - W-2 Statement issued not more than 12 months ago

5. Physician Letter

- A letter signed by the patient's physician
- Written on the physician's letterhead
- Letter must:
  - Confirm the patient's cancer diagnosis or the patient is being treated for cancer or the patient has a finding suggestive of cancer
  - Confirm the date(s) of diagnosis or treatment
  - Contain the physician's full name, address, specialty and medical license number

Physician Letter (cont.)

- http://phpa.dhmh.maryland.gov/cancer/Documents/MCF%20Updated%207.2013/Physician_Letter.pdf

NOTE: When a current recipient of a Cancer Treatment Grant is diagnosed with or has a suggestive finding of a second cancer, the organization administering the grant must seek approval for coverage of the second cancer.

Physician Letter - Form

(Insert Letterhead)

Physician Letter
Certification of Diagnosis

Date

Physician's Full Name
Address
Specialty
Medical License Number

Dear Maryland Cancer Fund Coordinator:

This letter is to certify that _____,
(Patient Name)

☐ has been diagnosed with _____, on _____.
(Type of Cancer) (Date of Diagnosis)

OR

☐ is being treated for _____, and began treatment on _____.
(Type of Cancer) (Date of Treatment)

OR

☐ has a finding suggestive of _____and needs to obtain a cancer diagnosis.
(Type of Cancer)

Sincerely,

Physician's Signature

6. Cancer Treatment Plan and Budget

- Form DHMH 4684
- http://phpa.dhmh.maryland.gov/cancer/CCPC%20Library%20Doc/MCF%20Cancer_Treatment_Plan_and_Budget_Form_4684_revised%2010.22%20(2).pdf

Cancer Treatment Plan and Budget - Form

Cancer Treatment Plan and Budget

Name of Organization/Entity applying for Grant:

Patient Name: Date of Birth:

Diagnosis: Date of Diagnosis:

Comments:

Treatment Plan from (date) to (date) Primary Treating Physician's Name:

Procedure and Frequency of Treatment	Date Anticipated	Estimated Costs	Basis for costs (Medicaid rate, HSCRC-regulated rate, or out of pocket insurance costs)
Sub Total for Treatment			
Indirect costs (Maximum of 7%)			
Total Requested (Treatment + Indirect)			

Form DHMH 4684 (Revised 10/22/2015)

7. Certification

- Form DHMH 4681
- http://phpa.dhmh.maryland.gov/cancer/CCPC%20Library%20Doc/MCF%20Certification_Form_4681_revised%2010.22%20(1).pdf

Certification - Form

Maryland CANCER FUND

Certification

As the Applicant and Grantee of the Maryland Cancer Fund (MCF) Cancer Treatment Grant, we certify that the award will not be used to supplant any existing funding for cancer treatment of this individual patient.

Organization Name: _____

Patient Name: _____

☐ We **do not** receive any other funding for payment and/or reimbursement for the patient's cancer treatment
(that is, either we do not receive any other funding for payment or reimbursement for *any* cancer treatment activities OR we receive funding for payment or reimbursement of cancer treatment but that funding is expended or obligated to other individuals for this Fiscal Year).

☐ We **do** receive other funding for payment and/or reimbursement for the patient's cancer treatment as listed below, but still request MCF funds:

Source	Title or Activity	Amount	Period for Activities

Rationale for need for MCF Funds:

☐ Estimated costs of cancer treatment exceed available funding for Payment

☐ Other _____

Form DHMH 4681 (Revised 10/22/2015)

We, the Applicant and Grantee of the MCF Cancer Treatment Grant, further certify that:

☐ The patient meets the residency, insurance and income requirements of the Maryland Cancer Fund program.

☐ We shall reimburse the provider(s), (or if we are a provider then we will accept) an amount not greater than the Medicaid or HSCRC-regulated rate (if applicable) for medical procedures performed.

☐ We will retain all records pertaining to this grant award for 3 years unless directed by the Maryland Department of Health & Mental Hygiene to retain longer.

☐ We will maintain, as confidential, all medical and financial information pertaining to the patient, their treatment and his/her family.

I certify that we are (check all that apply):

☐ A Maryland Local Health Department
☐ A cancer screening program funded by the Maryland Department of
☐ Mental Health and Hygiene, Center for Cancer Prevention and Control:

☐ Breast/Cervical Cancer Program
☐ Cigarette Restitution Fund Program
☐ Other: _____

_____ _____
Signature of Contact Date

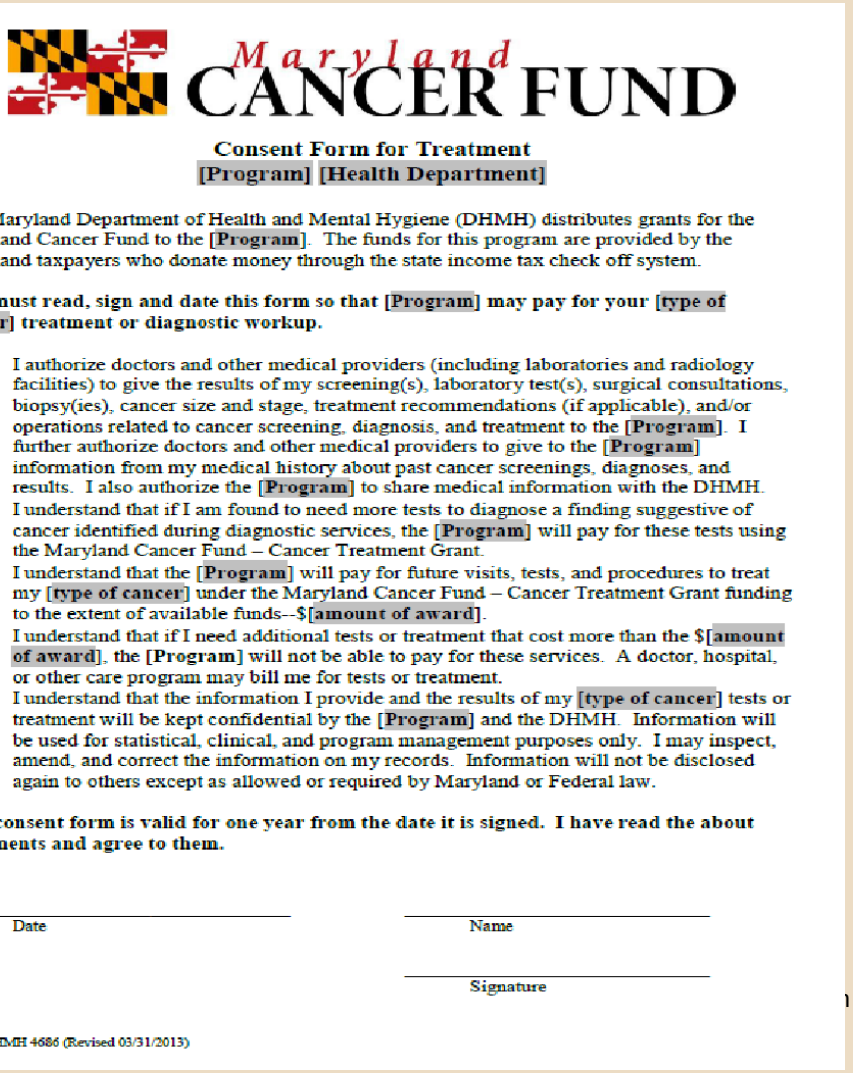
_____ _____
Name of Contact (Print) Name of Organization

Form DHMH 4681 (Revised 10/22/2015)

8. Consent

- Form DHMH 4686
- http://phpa.dhmh.maryland.gov/cancer/Documents/MCF%20Updated%207.2013/Consent_Form_4686.pdf

Consent - Form



Maryland CANCER FUND

Consent Form for Treatment
[Program] [Health Department]

The Maryland Department of Health and Mental Hygiene (DHMH) distributes grants for the Maryland Cancer Fund to the **[Program]**. The funds for this program are provided by the Maryland taxpayers who donate money through the state income tax check off system.

You must read, sign and date this form so that [Program] may pay for your [type of cancer] treatment or diagnostic workup.

- I authorize doctors and other medical providers (including laboratories and radiology facilities) to give the results of my screening(s), laboratory test(s), surgical consultations, biopsy(ies), cancer size and stage, treatment recommendations (if applicable), and/or operations related to cancer screening, diagnosis, and treatment to the **[Program]**. I further authorize doctors and other medical providers to give to the **[Program]** information from my medical history about past cancer screenings, diagnoses, and results. I also authorize the **[Program]** to share medical information with the DHMH.
- I understand that if I am found to need more tests to diagnose a finding suggestive of cancer identified during diagnostic services, the **[Program]** will pay for these tests using the Maryland Cancer Fund – Cancer Treatment Grant.
- I understand that the **[Program]** will pay for future visits, tests, and procedures to treat my **[type of cancer]** under the Maryland Cancer Fund – Cancer Treatment Grant funding to the extent of available funds--$**[amount of award]**.
- I understand that if I need additional tests or treatment that cost more than the $**[amount of award]**, the **[Program]** will not be able to pay for these services. A doctor, hospital, or other care program may bill me for tests or treatment.
- I understand that the information I provide and the results of my **[type of cancer]** tests or treatment will be kept confidential by the **[Program]** and the DHMH. Information will be used for statistical, clinical, and program management purposes only. I may inspect, amend, and correct the information on my records. Information will not be disclosed again to others except as allowed or required by Maryland or Federal law.

This consent form is valid for one year from the date it is signed. I have read the about statements and agree to them.

_____ Date

_____ Name

_____ Signature

Form DHMH 4686 (Revised 03/31/2013)

9. Fiscal Budget

- Form DHMH 432 A-H
- http://dhmh.maryland.gov/Pages/sf_gact.aspx

Fiscal Budget – Forms
DHMH 432 A, B, C

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICES CONTRACT PROPOSAL

A. Vendor Information: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Telephone: _____

Mailing Address (if other than shown above): _____
Federal Employer I.D.: _____ Minority Enterprise Yes No

Fiscal Year or Period for which Funds are Requested: _____

Type of Service To Be Funded: _____
Performance Measures Detail Attached Yes No

Area/Jurisdiction To Be Serviced: _____
Does the Organization Do Fundraising: Yes No
Are any of the State supported costs being used to generate fundraising dollars Yes No

Type of Proposal: New One-Time Only Renewal Supplement

B. Affirmations and Signature of Certifying Official: (Mark Appropriate Box(es))

- 5 If the local health officer has not signed below, a copy of this application was sent to that official simultaneously with this submission
- o A program narrative is attached for each service.

On behalf of the governing board or other executive authority of the above named organization, I affirm that the information and estimates conveyed in this application are true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Name Printed or Typed: _____ Title: _____

C. Third Party Review:

Reviewing Official	Signature	Date	Reviewed	Approved	Disapproved	Attached
Local Health Officer						
Advisory Council						
Local Govt. Auth.						
Regional Director						
Other (Specify)						

D. For DHMH Use Only _____

DHMH 432A (Rev. Feb. 1997)

PROGRAM BUDGET

PROGRAM ADMINISTRATION: _____
GRANT NUMBER: _____ DATE SUBMITTED: _____
CONTRACT PERIOD: _____ FISCAL YEAR: _____
ORGANIZATION: _____ PHONE #: _____
STREET ADDRESS: _____
CITY, STATE, COUNTY: _____ ZIP: _____
PROGRAM TITLE: _____
CHARGEABLE SERVICES (Y/N) _____ DHMH PROVIDES 50% OR MORE OF FUNDING (Y/N)
FOR DHMH USE ONLY _____

LINE ITEMS MAY NOT BE CHANGED	DHMH FUNDING REQUEST	SUPPLEMENTAL FUNDING REDUCTION	OTHER DIRECT FUNDING FED./STATE LOCAL & GOV'T	OTHER DIRECT FUNDING ALL OTHER AGENCY	OTHER DIRECT FUNDING TOTAL OTHER FUNDING	PROGRAM BUDGET
SALARIES/SPECIAL PAYMENTS						
FRINGE						
CONSULTANTS						
EQUIPMENT						
PURCHASE OF SERVICE						
RENOVATION						
CONSTRUCTION						
REAL PROPERTY PURCHASE						
UTILITIES						
RENT						
FOOD						
MEDICINES & DRUGS						
MEDICAL SUPPLIES						
OFFICE SUPPLIES						
TRANSPORTATION/TRAVEL						
HOUSEKEEPING/ MAINTENANCE/REPAIRS						
POSTAGE						
PRINTING/DUPLICATION						
STAFF DEVELOPMENT/ TRAINING						
CLIENT ACTIVITIES						
ADVERTISING						
INSURANCE						
LEGAL/ACCOUNTING/AUDIT						
PROFESSIONAL DUES						
OTHER (ATTACH ITEMIZATION)						
TOTAL DIRECT COSTS						
INDIRECT COST						
TOTAL COSTS						
LESS: CLIENT FEES						
DHMH FUNDING						

DHMH 432B (Rev. Feb. 1997)

PROGRAM BUDGET
ESTIMATED PERFORMANCE MEASURES

PROGRAM ADMINISTRATION: _____ AWARD NUMBER: _____
FISCAL YEAR: _____ CONTRACT PERIOD: _____ SUBMITTED: _____
ORGANIZATION _____ PHONE NUMBER: _____
ADDRESS: _____ ZIP: _____
PROGRAM TITLE: _____

PERFORMANCE MEASURE	BUDGET YEAR FY _____ ESTIMATE

DHMH 432C (Feb. 1997)

Fiscal Budget – Forms DHMH 432 D, E, F

ORGANIZATION: ______________________

AWARD NUMBER: ____________ FISCAL YEAR ____________

FOR DHMH USE ONLY: ______________________

SCHEDULE OF SALARY COSTS

MERIT SYSTEM ______

JOB TITLE OR CLASSIFICATION	NAME OF PERSON FILLING POSITION	GRADE AND STEP	HOURS PER WEEK	TYPE OF SERVICE	SALARY DHMH FUNDING	SALARY TOTAL PROGRAM BUDGET
TOTAL (MUST EQUAL 432B						

DHMH 432D (Rev. Feb. 1997)

ORGANIZATION: ______________________

AWARD NUMBER: ____________ FISCAL YEAR ____________

FOR DHMH USE ONLY: ______________________

SCHEDULE OF CONSULTANT COSTS

NAME OF CONSULTANT	PROFESSIONAL AREA	HIGHEST DEGREE HELD	HOURLY RATE	TOTAL HOURS	TOTAL DHMH COSTS	TOTAL PROGRAM BUDGET
TOTAL (MUST EQUAL 432B)						

DHMH 432E (Rev. Feb. 1997)

SCHEDULE OF EQUIPMENT COSTS

			DHMH FUNDING	TOTAL PROGRAM BUDGET
LIST OF MISCELLANEOUS EQUIPMENT COSTING UNDER $500 EACH				
LIST BELOW EACH EQUIPMENT ITEM COSTING OVER $500				
DESCRIPTION	CLIENT or OFFICE	NEW or REPLACEMENT		
TOTAL (MUST EQUAL 432B)				

DHMH432F (Rev. Feb. 1997)

Fiscal Budget – Forms
DHMH 432 G, H

PURCHASE OF SERVICE

SERVICE	VENDOR	PERFORMANCE MEASURES NUMBER UNITS PURCHASED (e.g., HRS, VISITS, ETC.)	DOLLARS	
			DHMH	TOTAL
TOTAL	XXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXX		

***Total must equal 432B*

DHMH432G (Feb. 1997)

ANTICIPATED SOURCES OF FUNDING

SOURCES	AMOUNT
DHMH AWARD	
DHMH SUPPLEMENT	
LOCAL GOV'T	
OTHER AWARD - FED, STATE OR PRIVATE AGENCY (SPECIFY)	
FEES	
DHMH CLIENT FEE COLLECTIONS	
OTHER CLIENT FEE COLLECTIONS	
MEDICAID PAYMENTS	
MEDICARE PAYMENTS	
INSURANCE/PRIVATE	
SSI	
OTHER - IDENTIFY	
FUNDRAISING/DONATIONS	
UNITED CHARITIES	
INTEREST	
Total Funding (Must Equal Total Costs in Total Program Budget on Budget Face Sheet	

IN-KIND CONTRIBUTIONS (IDENTIFY)	VALUE

TOTAL CASH PLUS IN-KIND	

DHMH432H (Rev. Feb.1997)

on
16
33

Application Process

1. Contact MCF Coordinator for fund availability
    a. Call (410) 767-6213
    b. If funds are available, then a grant number will be provided to continue
    c. If funds are unavailable, then further instructions will be provided
2. Complete MCF application
3. Submit signed Standard Grant Agreement

STANDARD GRANT AGREEMENT

- Legal contract between DHMH & Grantee
- Provides proposed award period and award amount
- Schedule of fiscal reporting
- Signed by Health Officer & DHMH
  - 3 copies
  - Blue ink

Award Confirmation

- Award Letter
  - To Health Officer & Program Coordinator
  - Terms and Conditions
  - Purchase Order

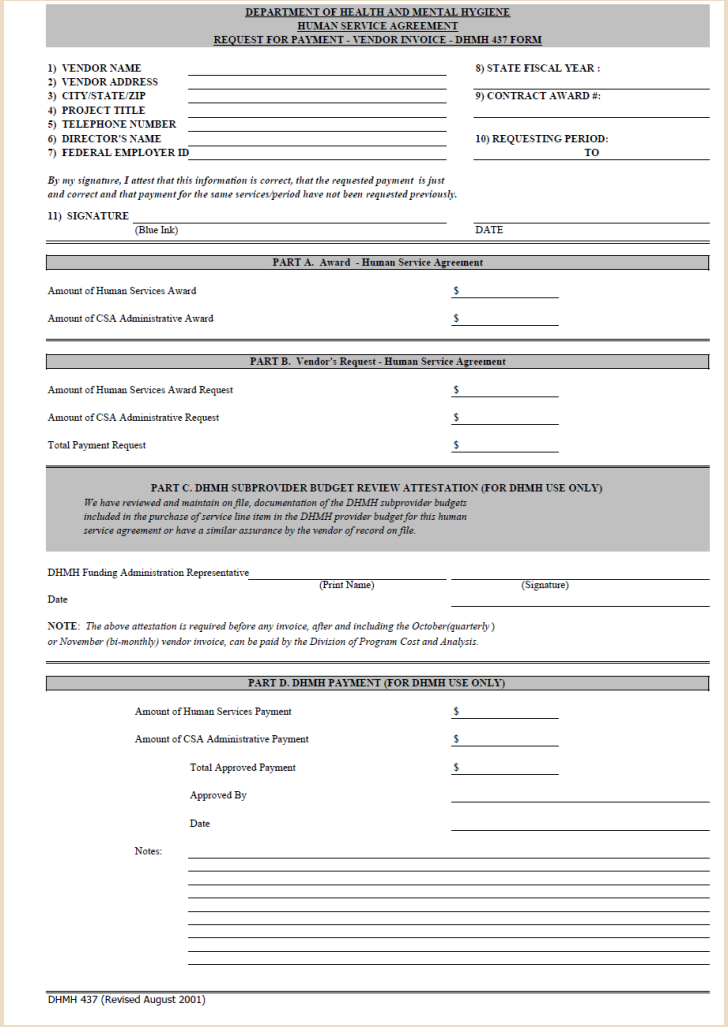
Fiscal Reporting

- Forms include:
  - Request for Payment and Report of Actual Expenses
    - DHMH Forms 437 and 438
    - Submitted Quarterly
  - Annual Report
    - DHMH Form 440
    - Submitted 60 days after grant end date

Fiscal Reporting (cont.)

- Final Comprehensive Report
  - Provides summary of grant activity
  - Submitted 60 days after grant end date

Fiscal Reporting (cont.)



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICE AGREEMENT
REQUEST FOR PAYMENT - VENDOR INVOICE - DHMH 437 FORM

1) VENDOR NAME
2) VENDOR ADDRESS
3) CITY/STATE/ZIP
4) PROJECT TITLE
5) TELEPHONE NUMBER
6) DIRECTOR'S NAME
7) FEDERAL EMPLOYER ID

8) STATE FISCAL YEAR :
9) CONTRACT AWARD #:
10) REQUESTING PERIOD:
TO

By my signature, I attest that this information is correct, that the requested payment is just and correct and that payment for the same services/period have not been requested previously.

11) SIGNATURE (Blue Ink) DATE

PART A. Award - Human Service Agreement

Amount of Human Services Award $
Amount of CSA Administrative Award $

PART B. Vendor's Request - Human Service Agreement

Amount of Human Services Award Request $
Amount of CSA Administrative Request $
Total Payment Request $

PART C. DHMH SUBPROVIDER BUDGET REVIEW ATTESTATION (FOR DHMH USE ONLY)

We have reviewed and maintain on file, documentation of the DHMH subprovider budgets included in the purchase of service line item in the DHMH provider budget for this human service agreement or have a similar assurance by the vendor of record on file.

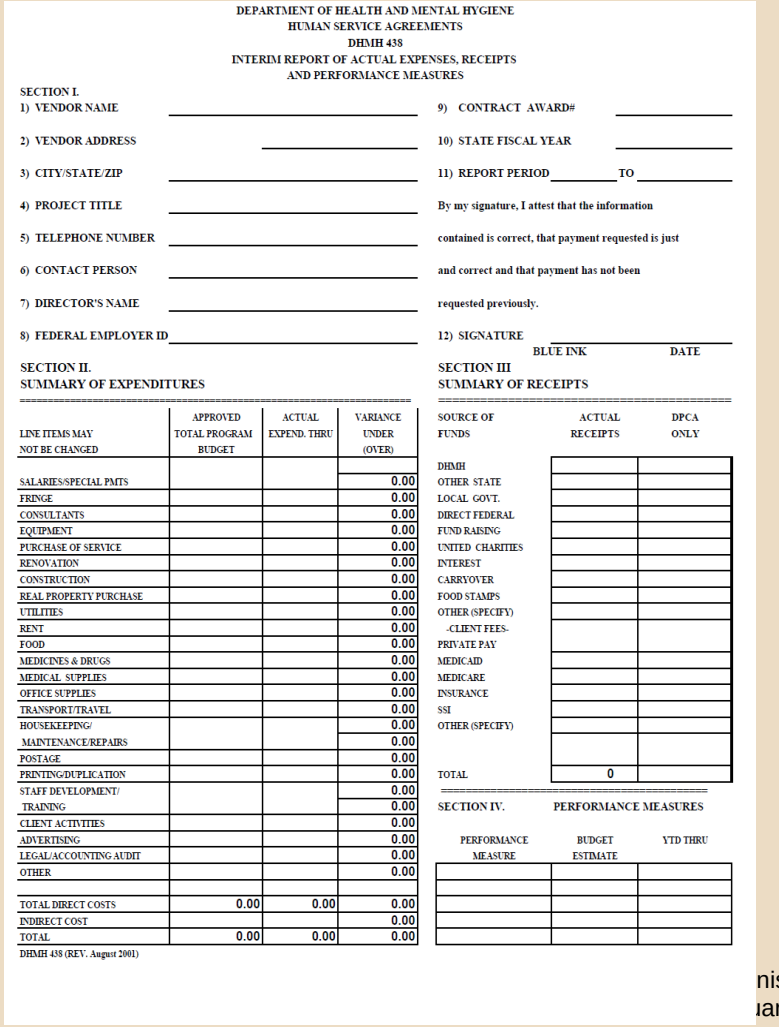
DHMH Funding Administration Representative (Print Name) (Signature)
Date

NOTE: *The above attestation is required before any invoice, after and including the October(quarterly) or November (bi-monthly) vendor invoice, can be paid by the Division of Program Cost and Analysis.*

PART D. DHMH PAYMENT (FOR DHMH USE ONLY)

Amount of Human Services Payment $
Amount of CSA Administrative Payment $
Total Approved Payment $
Approved By
Date
Notes:

DHMH 437 (Revised August 2001)



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICE AGREEMENTS
DHMH 438
INTERIM REPORT OF ACTUAL EXPENSES, RECEIPTS AND PERFORMANCE MEASURES

SECTION I.
1) VENDOR NAME
2) VENDOR ADDRESS
3) CITY/STATE/ZIP
4) PROJECT TITLE
5) TELEPHONE NUMBER
6) CONTACT PERSON
7) DIRECTOR'S NAME
8) FEDERAL EMPLOYER ID

9) CONTRACT AWARD#
10) STATE FISCAL YEAR
11) REPORT PERIOD TO

By my signature, I attest that the information contained is correct, that payment requested is just and correct and that payment has not been requested previously.

12) SIGNATURE BLUE INK DATE

SECTION II. SUMMARY OF EXPENDITURES

LINE ITEMS MAY NOT BE CHANGED	APPROVED TOTAL PROGRAM BUDGET	ACTUAL EXPEND. THRU	VARIANCE UNDER (OVER)
SALARIES/SPECIAL PMTS			0.00
FRINGE			0.00
CONSULTANTS			0.00
EQUIPMENT			0.00
PURCHASE OF SERVICE			0.00
RENOVATION			0.00
CONSTRUCTION			0.00
REAL PROPERTY PURCHASE			0.00
UTILITIES			0.00
RENT			0.00
FOOD			0.00
MEDICINES & DRUGS			0.00
MEDICAL SUPPLIES			0.00
OFFICE SUPPLIES			0.00
TRANSPORT/TRAVEL			0.00
HOUSEKEEPING/ MAINTENANCE/REPAIRS			0.00
POSTAGE			0.00
PRINTING/DUPLICATION			0.00
STAFF DEVELOPMENT/ TRAINING			0.00
CLIENT ACTIVITIES			0.00
ADVERTISING			0.00
LEGAL/ACCOUNTING AUDIT			0.00
OTHER			0.00
TOTAL DIRECT COSTS	0.00	0.00	0.00
INDIRECT COST			0.00
TOTAL	0.00	0.00	0.00

DHMH 438 (REV. August 2001)

SECTION III SUMMARY OF RECEIPTS

SOURCE OF FUNDS	ACTUAL RECEIPTS	DPCA ONLY
DHMH		
OTHER STATE		
LOCAL GOVT.		
DIRECT FEDERAL		
FUND RAISING		
UNITED CHARITIES		
INTEREST		
CARRYOVER		
FOOD STAMPS		
OTHER (SPECIFY)		
-CLIENT FEES- PRIVATE PAY		
MEDICAID		
MEDICARE		
INSURANCE		
SSI		
OTHER (SPECIFY)		
TOTAL	0	

SECTION IV. PERFORMANCE MEASURES

PERFORMANCE MEASURE	BUDGET ESTIMATE	YTD THRU

Fiscal Reporting (cont.)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HUMAN SERVICE AGREEMENTS
ANNUAL REPORT (DHMH 440)

SECTION I.

LOCAL HEALTH DEPT:	0
ADDRESS:	0
CITY, STATE, ZIPCODE:	0
PROJECT TITLE:	0
TELEPHONE #:	0
CONTACT PERSON:	
FEDERAL I.D. #:	0

GRANT NUMBER:	0
FISCAL YEAR:	0
AWARD PERIOD:	0
TOTAL DHMH AWARD:	0

SIGNATURE: (Blue Ink)

DATE:

SECTION II:

Total	0.00	0.00	0.00

SUMMARY OF EXPENDITURES

	Line Items	Final Approved Total Program Budget	Actual Expenditures	Variance Under/(Over)
1	Salaries			0.00
2	FICA			0.00
3	Retirement			0.00
4	Def Compensation			0.00
5	Health Insurance			0.00
6	Retiree Health Insurance			0.00
7	Unemployment Insurance			0.00
8	Workmen's Compensation			0.00
9	Overtime Earnings			0.00
10	Additional Assistance			0.00
11	Adjustments			0.00
12	Special Payments Payroll (SPP)			0.00
13	FICA-Special Payments Payroll			0.00
14	Unemployment Insurance - SPP			0.00
15	Contractual Services - Other			0.00
16	Postage			0.00
17	Telephone			0.00
18	In-state Travel			0.00
19	Out-of-State Travel			0.00
20	Training			0.00
21	Stipend/Tuition			0.00
22	Electricity			0.00
23	Water			0.00
24	Utilities - Combined			0.00
25	Gas and Oil			0.00
26	Insurance & Title			0.00
27	Vehicle Maintenance & Repair			0.00
28	Advertising			0.00
29	Ambulance Service			0.00
30	Personnel Investigations			0.00
31	Contractual Labor			0.00
32	Repairs			0.00
33	Photocopier Rental			0.00
34	Equipment Service			0.00
35	Software			0.00
36	Software Maintenance			0.00
37	Maintenance			0.00
38	Housekeeping			0.00
39	Indirect Cost			0.00
40	Laboratory Services			0.00
41	Photography (Commercial)			0.00
42	Printing			0.00
43	Purchase of Care			0.00
44	Trash Disposal			0.00
45	Human Service Contracts			0.00
46	Special Projects			0.00
47	Cleaning Supplies			0.00
48	Educational Supplies			0.00
49	Food			0.00
50	Medicine, Drugs and Chemicals			0.00
51	Medical Supplies			0.00
52	Office Supplies			0.00
53	Paper Articles			0.00
54	Computer Equipment			0.00
55	Office Equipment			0.00
56	Personal Computer Equipment			0.00
57	Medical Equipment			0.00
58	Office Equipment			0.00
59	Dues & Memberships			0.00
60	Insurance			0.00
61	Rent			0.00
62	Subscriptions			0.00
63	Other (Attach Detail)			0.00

SECTION III:

SUMMARY OF RECEIPTS

Source of Funds	Actual Receipts	DGA Use Only
DHMH STATE PAID EXPEND.		
Other State		
Local Government		
Direct Federal		
Fund Raising		
United Charities		
Interest		
Carryover		
Food Stamps		
Contingency Fund		
Other (Specify)		
- Client Fees -		
Private Pay		
Medicaid		
Medicare		
Insurance		
SSI		
Other (Specify)		
TOTAL	0.00	

SECTION IV:

RECONCILIATION (DPCA Use Only)

Total Receipts	0.00
Total Expenditures	0.00
Variance - Under/(Over)	0.00
(CSA Only) $ To Contingency Fund	

DPCA Action:

BY:

DATE:

DHMH 440 (Rev. January 2003)

MCF Final Comprehensive Report
T-10-00/FHA-000/M00P00000

Type of Cancer:

Stage of cancer at Diagnosis:

Age:

Race:

Gender:

County:

Amount of Funds Expended: (Provide a brief description of the expenditures.)

Brief Summary of Treat Received: (Provide a brief description of the treatment provided.)

Wawa Gift Cards

- $10 Wawa gift cards for patients to be used for transportation to and from medical appointments
- Submit request to MCF Coordinator

QUESTIONS?

MCF Coordinator

(410) 767-6213

Prevention and Health Promotion Administration

http://phpa.dhmh.maryland.gov